STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			-		R
		HAL034116	B. WING		05/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
SALEM TI	ERRACE AND MEMORY	CARE	SALISBURY R		
0/0/15	SHIMMADV ST	ATEMENT OF DEFICIENCIES	SALEM, NC 2	PROVIDER'S PLAN OF CORRECTION	d over
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
	The Adult Care Licens annual and follow-up through 05/03/23.	sure Section conducted an survey from 05/02/23			
D 283	10A NCAC 13F .0904 Service	(a)(2) Nutrition and Food	D 283		
	(a) Food Procurement Homes: (2) Facilities with a lice more residents shall evith Rules Governing Nursing Homes, Adult Institutions set forth in which are hereby incoincluding subsequent	Nutrition and Food Service and Safety in Adult Care censed capacity of 13 or ensure food services comply the Sanitation of Hospitals, to Care Homes and Other and 15A NCAC 18A .1300 or porated by reference, amendments, assuring and serving of food and ary conditions.			
	interviews, the facility and safety guidelines providing feeding ass	s, record reviews, and failed to ensure sanitation			
	from 8:15am - 8:45an -Resident #2 and Res	eakfast meal on 05/03/23 n revealed: sident #7 were seated at a are Unit (SCU) dining room.			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		R		
		HAL034116	B. WING	B. WING		05/03/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
SALEM TE	ERRACE AND MEMORY	CARE	SALISBURY R				
_		WINSTO	N SALEM, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 283	Continued From page	1	D 283				
	-The Memory Care C seated in a chair betw Resident #7 on her le rightThe MCC was not wijelly to Resident #7's -The MCC lifted Resident with an unglov sanitizing or washing -The MCC lifted a pie #7's plate to his mout -The MCC wiped her napkin and turned to lifted her biscuit to he handThe MCC did not we her hands as she confood and drink for eac -The MCC did not we her hands as she alte the two residentsThe MCC used a naresidents' mouths with sanitizing her hands to 1. Review of Resident with sanitizing her hands to 1. Review of Resident with a replacement and Review of Resident with eating Based on observation interviews, it was determined to the search of the search with eating Based on observation interviews, it was determined to the search of the search with eating Based on observation interviews, it was determined to the search of the search with eating Based on observation interviews, it was determined to the search of the search with eating Based on observation interviews, it was determined to the search with eating Based on observation interviews, it was determined to the search with eating Based on observation interviews, it was determined to the search with eating Based on observation interviews, it was determined to the search with eating Based on observation interviews, it was determined to the search with eating Based on observation interviews, it was determined to the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation interviews and the search with eating Based on observation in	coordinator (MCC) was ween the two residents with off and Resident #2 on her earing gloves while applying and Resident #2's biscuits. It is dent #7's biscuit to his ed hand and without her hands. It is dent #7's her right to Resident #7's her right to Resident #2 and it is mouth with an ungloved ar gloves, sanitize or wash stinued to alternate bites of its resident. It is a gloves, washing or in the properties of the properties of the resident. It is considered to a grows included dementia, it is diabetes. It is a seessment and care evealed the activity of daily its is grown in the properties of the resident #2 as being totally grown, record reviews and the properties are grown and the properties with the properties of the					
	Refer to the interview	with a personal care aide					

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(PCA) on 05/03/23 at 8:40am.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL034116	B. WING			R 5/ 03/2023
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
SALEM T	ERRACE AND MEMORY	CARE	.D SALISBURY ROA ON SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 283	Continued From pag	e 2	D 283			
	Refer to the interview 05/03/23 at 8:50am.	wwith a second PCA on				
	Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am.					
	Refer to the interview 05/03/23 at 2:15pm.	v with the Administrator on				
	2. Review of Resident #7's current FL-2 dated 02/16/23 revealed: -Diagnoses included dementia and gastro esophageal reflux diseaseResident #7 required personal care assistance with feeding.					
	plan dated 02/21/23 living documented Re	#7's assessment and care revealed the activity of daily esident #7 as requiring th eating, needing set up, sening cartons.				
	Based on observations, record reviews and interviews, it was determined that Resident #7 was not interviewable.					
	Refer to the interview (PCA) on 05/03/23 a	v with a personal care aide t 8:40am.				
	Refer to the interview 05/03/23 at 8:50am.	v with a second PCA on				
	Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am.					
	Refer to the interview 05/03/23 at 2:15pm.	with the Administrator on				
	Interview with the PC	 CA on 05/03/23 at 8:40am				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL034116	B. WING		05/03	3/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SALEM TERRACE AND MEMORY CARE			SALISBURY R SALEM, NC 2'			
OUR MADE OF THE MEDICAL PROPERTY OF THE PROPER			· ·	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 283	Continued From page	e 3	D 283			
	eating when she first facility, but she could who trained herShe had been told to providing feeding ass provide dignity, even food with bare handsShe was told to wash residents. Interview with a second 8:50am revealed: -She was trained not touching resident's fo with eatingShe was trained whe facility, but could not trained her in feeding	to wear gloves, even when od, when assisting residents en she started working at the remember when or who had assistance.				
	revealed: -Staff had not been to during feeding assistatesShe had worked at the could not remember well.	ne facility for 10 years and who trained her. hy she touched 2 different are hands without washing				
	Interview with the Administrator on 05/03/23 at 2:15pm revealed: -She was not aware staff were feeding residents by touching their food without washing their hands or wearing glovesStaff were trained not to wear gloves while					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034116	B. WING	B. WING		R /03/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	= ZIP CODE	03	103/2023
		2609 OLI	D SALISBURY RO			
SALEM TI	ERRACE AND MEMORY	CARE WINSTOI	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 283	worn gloves or washe needed to touch resid -Staff should make ev while assisting with fe	istance but should have ed their hands when they dents' food. very effort to use utensils eeding residents.	D 283			
D 299	-The MCC was responsible for making sure staff were following sanitation guidelines while providing feeding assistance to residents. D 299 10A NCAC 13F .0904(d)(3) Nutrition And Food		D 299			
D 239	Service 10A NCAC 13F .0904 (d) Food Requirement (3) Daily menus for reconstruction on the U.S. Department guidelines for American hereby incorporated by subsequent amendment guidelines can be found https://dietaryguidelines.	1 Nutrition And Food Service ats in Adult Care Homes: egular diets shall be based ent of Agriculture Dietary ans 2020-2025, which are by reference including ents and editions. These	D 299			
	interviews, the facility	ns, record reviews, and failed to ensure 8 ounces of e daily to residents on the				
	kitchen on 05/02/23 a	alk-in refrigerator in facility at 10:15am revealed there ble milk and 4 boxes of 48				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMI LETED
		HAL034116	B. WING		R 05/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CALEMIT	ERRACE AND MEMORY	2609 OLD	SALISBURY R	OAD	
SALEIVI II	ERRACE AND MEMORY	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 299	Continued From page	÷ 5	D 299		
	count of 2% and whol	le milk in 8-ounce cartons.			
	Review of the facility's week at a glance menu for week 1 for Tuesday revealed milk was not listed to be served with lunch on 05/02/23. Observation of the lunch meal service in the SCU on 05/02/23 between 11:45am and 12:35pm revealed: -The kitchen staff delivered 2 meal carts to the SCU dining room at 11:45am.				
		iners of milk on either cart.			
	 Thirty residents were were not served or of 	e served meals with tea but			
		MA) or personal care aide			
	(PCA) staff retrieved				
	week 1 for Wednesda	s week at a glance menu for ay revealed a serving of milk a breakfast on 05/03/23.			
	SCU on 05/03/23 bet	eakfast meal service in the ween 8:15am and 8:45am			
	revealed: -The kitchen staff deli SCU dining room at 8	vered 2 meal carts to the			
	•	ners of orange juice and 2			
	containers of coffee, leither cart.	but no containers of milk on			
	_	served meals with orange			
	juice and coffee, but r offered.	no milk was served or			
		d for milk from the kitchen.			
	05/03/23 at 8:40am re- -Small cartons or galle	ons of milk were usually			
	-Milk was usually on t	he carts for the breakfast			
	-Small cartons or gallesent on the meal carts	ons of milk were usually s from the kitchen.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		HAL034116	B. WING		05/03	3/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEMITE	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD		
WINSTON			SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 299	9 Continued From page 6		D 299			
	checked with the kitch	e cart, a staff would have nen to get it. nat milk was not sent for				
	8:50am revealed: -Milk was sent on the -The milk was usually but she was not sure -When milk was not o	meal carts from the kitchen. on the carts for breakfast, if it was sent for dinner. on the meal cart, a staff that ding assistance would go to milk				
	Interview with a Memory Care Coordinator (MCC) on 05/03/23 at 8:58am revealed: -Milk was sent on the meal carts from the kitchen. -The milk was usually on the carts for each meal. -She did not observe in the dining room during every meal and was not sure if milk had been sent for every meal on the meal carts. -If milk did not come on the cart, a staff should have checked with the kitchen to provide them for the residents. -She assisted with resident meals for breakfast on 05/03/23, but did not notice that residents were not served milk. -She did not send staff to retrieve milk from the kitchen.					
	9:40am revealed: -The dietary staff wer on the meal carts for -She knew milk was t breakfast and dinner -A serving of milk was for the breakfast mea	o be served to residents for meals. s on the menu for 05/03/23				

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place milk on the meal cart for SCU residents on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		HAL034116	B. WING		1	3/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TERRACE AND MEMORY CARE			SALISBURY R			
			SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 299	9 Continued From page 7		D 299			
		t. CU did not come to the c for breakfast 05/03/23.				
	05/03/23 at 9:50am re-The dietary staff were on the meal carts for 3-He knew residents whereakfast. -The dietary staff had carts out to the SCU ameal carton 05/03/23-Staff from the SCU d to ask for milk for the 05/03/23. Interview with the Adr 2:15pm revealed: -She was not aware the	e responsible to send milk SCU residents. vere to be served milk with been rushed to get meal and did not place milk on the 3 for breakfast. lid not come to the kitchen breakfast meal service on				
	staff to go immediatel ask for milk for the res	be served to residents for				
D 306	10A NCAC 13F .0904 Service	4(d)(4) Nutrition and Food	D 306			
	(d) Food Requiremen	Nutrition and Food Service nts in Adult Care Homes: rved to each resident at n to other beverages.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034116	B. WING		05	R 5/03/2023
	ROVIDER OR SUPPLIER	CARE 2609 OL	DDRESS, CITY, STATE D SALISBURY ROA N SALEM, NC 271	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 306	Continued From page	8	D 306			
	Based on observation interviews, the facility served at each meal, beverages, in the Special The findings are: Observation of the lur on 05/02/23 between revealed: -The kitchen staff deli SCU dining room at 1-There were no contary and water. -A personal care aide pitcher from the kitcher the middle of the dining wanted water.	failed to ensure water was in addition to other ecial Care Unit (SCU). The meal service in the SCU 11:45am and 12:35pm Vered 2 meal carts to the				
		ed their hand at 12:14pm,				
	SCU on 05/03/23 betrevealed: -The kitchen staff deli SCU dining room at 8-There were 2 contain containers of coffee, lon either cartResidents were serv and coffee, but no ward to a side of the containers of coffee on either cartResidents were serv and coffee, but no ward to a side of the containers of coffee on either cartResidents were serv and coffee, but no ward to a side of the containers of	ners of orange juice and 2 but no containers of water ed meals with orange juice ster. ater pitcher from the kitchen who wanted water.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL034116	B. WING		0:	R 5/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
SAI FM TI	ERRACE AND MEMORY	2609 OL	D SALISBURY ROA	ND		
OALLIN II	ERRAGE AND MEMORI	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 306	Continued From pag	e 9	D 306			
	revealed: -Water pitchers were the kitchenThe water pitchers weach mealIf water was not on a checked with the kitchersShe realized at the e 05/02/23 and breakfadid not have water at staff to get some wat Interview with a second 8:50am revealed: -Water was sent on the kitchenThe water was usual mealWhen water was not that was not providing to the kitchen to get some the second	end of the meals for lunch ast 05/03/23 that residents and asked one of the other fer from the kitchen. and PCA on 05/03/23 at the meal carts from the killy on the carts for each at on the meal cart, a staff g feeding assistance would let it. and residents did not have				
	on 05/03/23 at 8:58a -Water was sent on t kitchen.	nory Care Coordinator (MCC) m revealed: he meal carts from the ally on the carts for each				
	-She did not observe meal and so did not l for every meal on the -If water did not com- have checked with the for the residents.	in the dining room every know if water had been sent e meal carts. e on the cart, a staff should he kitchen to provide water esident meals for breakfast				

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			1		_	
			D MANAGE		R	
		HAL034116	B. WING		05/0	3/2023
NAME OF D	ROVIDER OR SUPPLIER	STDEET ADI	ORESS, CITY, STA	TE 710 CODE		
NAME OF FI	NOVIDER OR SUFFLIER		, ,	,		
SALEM TE	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
			1	DEFICIENCY)		
D 306	Continued From page	10	D 306			
D 000	Continued From page	- 10	5 000			
	05/03/23 but did not r	notice that residents were				
	not served water.					
	-She did not send sta	ff to retrieve water from the				
	kitchen.					
	Tatorion.					
	Interview with a dietai	ry aide on 05/03/23 at				
	9:40am revealed:	ry alac on ooroorzo at				
		. was a said to the said water				
		responsible to send water				
	on the meal carts for SCU residentsShe knew water was to be served to residents at					
	every meal.					
	-The dietary staff have	e just been rushed and did				
	not place water on the	e meal cart for SCU				
	residents on 05/02/23	for lunch and 05/03/23 for				
	breakfast.					
	-A PCA from the SCU	came to the kitchen later to				
		h 05/02/23 and breakfast				
	05/03/23.	11 03/02/23 and breaklast				
	03/03/23.					
	Interview with the Die	ton, Monogor (DM) on				
		tary Manager (DM) on				
	05/03/23 at 9:50am re					
	,	e responsible to send water				
	on the meal carts for	SCU residents.				
	-He knew residents w	ere to be served water with				
	every meal.					
	-The dietary staff have	e just been rushed to get				
		SCU and did not place water				
		5/02/23 for lunch and on				
	05/03/23 for breakfas					
		came to the kitchen about				
		arts were sent to ask for				
		/23 or breakfast 05/03/23.				
	water for furion 05/02/	/23 ปกมเซลเกลร์เ บิว/บิ3/23.				
	Ind					
		ministrator on 05/03/23 at				
	2:15pm revealed:					
	-She was not aware t	hat water had not been				
	served until later for lu	unch on 05/02/23 and				
	breakfast on 05/03/23	3 in the SCU.				
	-If water was not sent	on meal carts, she				

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expected staff to go immediately to the kitchen

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		HAL034116	B. WING		05/03/2023
	ROVIDER OR SUPPLIER	2609 OLD	DRESS, CITY, STA SALISBURY R I SALEM, NC 2	OAD	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 306	Continued From page 11		D 306		
	door and ask for the v	vater for the residents. to be served to residents at			
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310		
	(e) Therapeutic Diets (4) All therapeutic die supplements and thick served as ordered by This Rule is not met a Based on observation	s, record reviews and			
	supplement was serve sampled residents (#2 during breakfast and I (Resident #2 and #6)	failed to ensure a nutritional ed as ordered for 3 of 3 2, #6 and #4) observed unch meal service and a resident who had an in drink for wound healing			
		: #2's current FL2 dated gnoses included dementia, diabetes.			
		2's physician's orders dated e was an order for a house es a day with meals.			
	Special Care Unit (SC 11:45am and 12:35pn -The kitchen staff deli SCU dining room at 1	vered 2 meal carts to the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL034116	B. WING		R 05/03/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CALEMI	EDDACE AND MEMORY	2609 OLD	SALISBURY R	OAD		
SALEM TERRACE AND MEMORY CARE WINSTON			SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 12	D 310			
	cartResident #2 was ser green beans, rice, rol unsweetened teaA personal care aide pitcher from the kitchreturn with any nutritic-Resident #2 was prostaff and consumed le-No nutritional supple Resident #2 during thand 12:35pm. Observation of the br SCU on 05/03/23 bet revealed: -The kitchen staff deli SCU dining room at 8-There were no nutriticartResident #2 was ser bacon, a biscuit and o-A PCA retrieved a wat 8:39am, but did no supplementsResident #2 was prostaff and consumed le-No nutritional supple Resident #2 during the 8:15am and 8:45am. Observation of the kit 10:15am revealed Rediet list to receive a h day with meals.	ved bar-b-que chicken, I, crème pie and a (PCA) retrieved a water en at 12:14pm, but did not onal supplements. vided feeding assistance by ess than 25% of the meal. ement was served to the lunch meal from 11:45am eakfast meal service in the tween 8:15am and 8:45am ivered 2 meal carts to the 3:15am. ional supplements on either twed scrambled eggs, grits, orange juice. Froater pitcher from the kitchen to return with any nutritional evided feeding assistance by the ses than 50% of the meal. Event was served to the breakfast meal from acchen on 05/02/23 at the sident #2 was listed on the ouse supplement 3 times a				
	9:30am revealed ther	chen freezer on 05/03/23 at re was a full box of nutritional				

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serve with meals.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILBING			R
		HAL034116	B. WING		05	5/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY ROA			
SALEM TI	ERRACE AND MEMORY	CARE WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	e 13	D 310			
		ns, record reviews and ermined that Resident #2 e.				
	Refer to the interview with a PCA on 05/03/23 at 8:40am. Refer to the interview with a second PCA on 05/03/23 at 8:50am. Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am.					
	Refer to the interview 05/03/23 at 9:40am.	with a dietary aide on				
	Refer to the interview (DM) on 05/03/23 at 9	with the Dietary Manager 9:50am.				
	Refer to the interview 05/03/23 at 2:15pm.	with the Administrator on				
	03/31/23 revealed: -Resident #6's diagnoschizophrenia and hy -There was an order	t #6's current FL2 dated bses included dementia, perlipidemia. for a house supplement with meals and at bedtime.				
	Special Care Unit (SC 11:45am and 12:35pr -The kitchen staff deli SCU dining room at 1 -There were no nutrit cart.	vered two meal carts to the 1:45am. ional supplements on either ved bar-b-que chicken, I, crème pie and tea.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			
		HAL034116	B. WING		05	R 5/03/2023
	PROVIDER OR SUPPLIER	CARE 2609 (T ADDRESS, CITY, STAT	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 310	-A personal care aide pitcher from the kitch return with any nutriti -No nutritional supple Resident #6 during the and 12:35pm. Observation of the br SCU on 05/03/23 bet revealed: -The kitchen staff del SCU dining room at 8-There were no nutriticartResident #6 was ser bacon a biscuit and c-Resident #6 at nearl -A PCA retrieved a wat 8:39am, but did no supplementsNo nutritional supple Resident #6 during the 8:15am and 8:45am. Observation of the kit 10:15am revealed Rediet list to receive a high day with meals and a complements in a box serve with meals. Based on observation interviews, it was detivas not interviewable	en at 12:14pm, but did not conal supplements. Iment was served to be lunch meal from 11:45am eakfast meal service in the ween 8:15am and 8:45am evered two meal carts to the strain supplements on either extra ved scrambled eggs, grits, range juice. If y 100 percent of her meal eater pitcher from the kitchen that return with any nutritional ement was served to be breakfast meal from extra	D 310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			7 55.25			R
		HAL034116	B. WING		05	5/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	ΓΕ, ZIP CODE		
		2609 OL	D SALISBURY RO			
SALEM TI	ERRACE AND MEMORY	CARE WINSTO	N SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	e 15	D 310			
	Refer to the interview 05/03/23 at 8:50am.	with a second PCA on				
		with the Memory Care n 05/03/23 at 8:58am.				
	Refer to the interview with a dietary aide on 05/03/23 at 9:40am.					
Refer to the interview with the Dieta (DM) on 05/03/23 at 9:50am.						
	Refer to the interview with the Administrator on 05/03/23 at 2:15pm. Interview with a PCA on 05/03/23 at 8:40am revealed: -Nutritional supplements were sent on the meal carts from the kitchenTwo residents were to receive nutritional supplements with their meals.					
	carts for each mealIf nutritional supplem	ements were usually on the nents were not on the cart, a sked with the kitchen to get				
	themShe got busy serving assistance to a reside nutritional supplemen	g and providing feeding ent and did not know why its were not on the carts for d breakfast 05/03/23.				
	8:50am revealed: -Nutritional suppleme carts from the kitchen -She knew two reside nutritional supplemen	ents were to receive				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL034116	B. WING	B. WING		R / 03/2023	
NAME OF PROVIDER OR SUPPLIER SALEM TERRACE AND MEMORY OF	2609 OLD	DRESS, CITY, STATE SALISBURY ROA I SALEM, NC 271	ND			
PREFIX (EACH DEFICIENCY	4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
staff that was not proviously go to the kitcher. She helped late in the assistance for a resider resident had a nutrition breakfast on 05/03/23 get the nutritional supplement with a MCC revealed: -Nutritional supplement carts from the kitchentTwo residents were to supplements with their. The nutritional supplement carts for each meal carts for each meal, and was unsurer residents were not see during meal timesIf nutritional supplements were not see during meal timesIf nutritional supplement cart, a staff should have to provide nutritional supplements. Interview with a dietant 9:40am revealed: -The dietary staff were nutritional supplements SCU residents who we supplements with mean supplements with mean supplements sent on the dietary staff had place them on the mean objool/2/23 for lunch and not medication aide (I	vere not on the meal cart, a riding feeding assistance in to get them. It is meal to finish with feeding ent and was not sure if that and supplement for or if any staff had went to plements. on 05/03/23 at 8:58am In the were sent on the meal or receive nutritional remails. It is meal to finish were usually on the eal. In the dining room every to for how many times the red nutritional supplements were not on the meal we checked with the kitchen supplements for the responsible for sending its on the meal carts for the recordered nutritional	D 310				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL034116	B. WING		05	R 5/03/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE			
SALEM TI	ERRACE AND MEMORY	CARE	SALISBURY ROA				
	0.0000000000000000000000000000000000000		N SALEM, NC 271		000000000000000000000000000000000000000		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 310	Continued From pag	e 17	D 310				
	for the residents' nut on 05/02/23 or breal	ritional supplements for lunch kfast on 05/03/23.					
	Interview with the DN revealed:	/l on 05/03/23 at 9:50am					
	-The dietary staff were responsible for sending nutritional supplements on the meal carts for SCU residents ordered nutritional supplements with meals. -He knew two residents were to receive nutritional supplements sent on the breakfast, lunch and dinner meal carts. -The dietary staff had been rushed to get meal carts out to the SCU and did not place the						
	nutritional suppleme	nts on the meal cart on					
	-No MA or PCA from	the SCU came to the residents' nutritional					
		th on 05/02/23 or breakfast					
	Interview with the Ad 2:15pm revealed:	ministrator on 05/03/23 at					
	-She was not aware	nutritional supplements were on 05/02/23 and breakfast					
	-If the nutritional sup	plements were not sent on expected staff to go to the					
	kitchen door and ask supplements for the	for the nutritional					
	-She expected all nu	tritional supplements to be					
	meals as ordered.	and given to residents with					
		nt #4's current FL2 dated agnoses included diabetes					
	· ·	#4's wound care clinic s dated 03/08/23, 04/10/23					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL034116	B. WING		05	R / 03/2023	
NAME OF PROVIDER OR SUPPLIER	2609 OLI	DDRESS, CITY, STATE				
SALEM TERRACE AND MEMORY CA	ARE	N SALEM, NC 271				
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
abdomenThere were orders to supplement daily for wood observation of the kitch 9:30am revealed there supplements available. Interview with a dietary 9:40am revealed: -The dietary staff were nutritional supplements for residents who were -She was not aware Rea a daily protein supplements of the dietary staff were out nutritional supplements for resided. He did not know that Refor a daily protein supplements for a daily protein supplement every day, any protein supplement. She did not see discharge of the supplement every day, any protein supplement.	start drinking a protein bund healing. Then freezer on 05/03/23 at were no protein to provide to Resident #4. Taide on 05/03/23 at responsible to provide and protein supplements ordered supplements. Pesident #4 had an order for ment. The ary Manager (DM) on realed: The argument of t	D 310	DEFICIENCY			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			74. BOILBING.			R	
		HAL034116	B. WING		05/03/2	2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
SALEM TI	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD			
		WINSTON	SALEM, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 310	Continued From page	e 19	D 310				
	Telephone interview was Resident #4's primary office on 05/03/23 at a -Resident #4 was refectinic for an abdomina -The PCP would experiment wound care clinic to have resident #4 needed wound healing. -The facility should haprovider at the wound written order if the factorial -There was no document requested a written or supplement.	with a representative from a care provider's (PCP) 2:26pm revealed: erred to the wound care all wound. ect any instructions from the nave been followed up on. If a protein supplement for a protein supplement for a care clinic to obtain a					
	Resident #4's wound 4:46 revealed: -Resident #4 had bee to her abdomenThe discharge instru 03/08/23 and afterwa for a daily protein sup-If the facility needed they should have conprescriptions would helectronically to the re-It was expected that protein supplement, ecounter, and administ to Resident #4She could not speak Resident #4 did not resupplement daily. Interview with the Res (RCC) on 05/03/23 at	care clinic on 05/03/23 at en seen for an open wound ctions for Resident #4 on rd were considered orders explement for wound healing. Orders written differently, tacted the office and ave been written or sent esident's pharmacy. The facility would obtain the even if they were over the ter the protein supplements to negative effects if eceive the protein sident Care Coordinator in 10:40am revealed:					
	supplement daily. Interview with the Res (RCC) on 05/03/23 at	sident Care Coordinator : 10:40am revealed: dents' orders when they					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
					R	
		HAL034116	B. WING		05/03/2	2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
			SALISBURY R			
SALEM TE	ERRACE AND MEMORY	CARE	SALEM, NC 2			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 310	Continued From page	e 20	D 310			
	that the wound care pcare orders on, but no supplement. -He would not have lother discharge summa facility's signed order it. -He missed the instruthe wound care clinic supplement daily. -If he had seen the incalled the PCP and reto the pharmacy. Interview with the Adr 2:15pm revealed: -She was not aware Fon a discharge summ protein supplement error a discharge summ protein supplement error and instructions on a discharge control instructions on a discharge summon control instructions on a discharge control instructions on a discharge summon control instructions on a discharge control instruction on a discharge control instructio	poked through the pages of ary, because he had the sheet with other orders on ctions for Resident #4 from to start drinking a protein structions, he would have equested orders to be sent ministrator on 05/03/23 at Resident #4 had instructions eary to start drinking a very day. The facility's order sheet that at's going to appointments. The RCC to review that facility's order sheet. The facility's order sheet it the facility's order sheet. The facility's order sheet, seed.				
	followed as ordered.					
D 358	10A NCAC 13F .1004 Administration	l(a) Medication	D 358			
	(a) An adult care hor preparation and admi	I Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with:				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034116	B. WING		R 05/03/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SAI FM TI	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	21	D 358			
	(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.					
	This Rule is not met a TYPE A2 VIOLATION					
	Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1 and #4) who had orders for a narcotic pain medication and an antipsychotic medication (#1), and orders for vitamin and mineral supplements for wound healing (#4).					
	The findings are:					
	1. Review of Resident #1's current FL2 dated 08/24/22 revealed diagnoses included Alzheimer's disease, dementia, insomnia, hypertension and osteoporosis.					
	dated 10/04/22 revea hydrocodone-acetam	inophen 5-325mg (a ised to treat moderate pain)				
	medication administrative revealed: -There was an entry for hydrocodone-acetaminablet every 6 hours so 6:00am, 12:00pm, an anothere was document hydrocodone-acetaminable.	or inophen 5-325mg, take 1 cheduled at 12:00am, d 6:00pm. tation				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034116	B. WING		05/0	3/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	•	
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE AND MEMORY	CARE WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 22	D 358			
	02/16/23, and 02/18/2 medication to arrive from the pharm takeThere was documen hydrocodone-acetam administered at 6:00a and 02/17/23 due to varrive from the pharm takeThere was documen hydrocodone-acetam administered at 12:00 and 02/18/23 due to vadministration and net the pharmacy from horal the pharmacy from the pharmacy, physically prescription needed at Review of Resident #	23 due to waiting for the rom the pharmacy or ake. tation inophen was not am on 02/13/23, 02/15/23, waiting for the medication to facey or physically unable to tation inophen was not 0pm on 02/13/23, 02/15/23, medication not available for ew prescription was sent to ospice. tation inophen was not 0pm on 02/13/23, 02/14/23, 2/17/23, and 02/18/23 due lication to arrive from the unable to take, or				
	-Hydrocodone-acetar	ninophen 5-325mg take 1				
	of 60 tablets which wa	vas dispensed for a quantity as a 15-day supply. tation that the last tablet				
	signed out was at 6:00pm on 02/12/23. Review of Resident #1's CSCS dated 02/18/23 revealed: -Hydrocodone-acetaminophen 5-325mg take 1 tablet every 6 hours was dispensed for a quantity of 60 tablets which was a 15-day supplyThere was documentation that the first tablet signed out was at 6:00pm on 02/18/23There was no documentation					

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hydrocodone-acetaminophen 5-325mg was

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Division of	<u>of Health Service Regu</u>	lation					
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUF	PPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION	NUMBER:	A. BUILDING:		COMPLI	ETED
				_		_	
				D WING		F	
		HAL034116	i	B. WING		05/0	3/2023
NAME OF D	ROVIDER OR SUPPLIER		STREET ADI	ORESS, CITY, STA	TE ZID CODE		
IVAIVIL OI II	NOVIDEN ON OUT LIEN						
SALEM T	ERRACE AND MEMORY	CARE		SALISBURY R			
			WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIE	NCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDE		PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFO	DRIMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
					22.18.2.18.1		
D 358	Continued From page	e 23		D 358			
	signed out between 1	2:00am on 02/13	/23 and				
	12:00pm on 02/18/23						
	Review of Resident #	1's March 2023 e	MAR				
	revealed:						
	-There was an entry f	or					
	hydrocodone-acetam		ı, take 1				
	tablet every 6 hours s						
	6:00am, 12:00pm, an		- ,				
	-There was documen	•					
	hydrocodone-acetam						
	administered on 03/0	•	r 6:00nm				
	due to waiting for the		•				
	the pharmacy and ph						
	-There was documen		take.				
	hydrocodone-acetam						
	administered on 03/0		uo to				
		•	ue to				
	physically unable to to -There was documen						
	hydrocodone-acetam		0.00				
	administered on 03/0						
	12:00pm or 6:00pm d	lue to waiting on a	a retili trom				
	the pharmacy.						
	D . (D , "	41 0000 1 1 1	20/40/00				
	Review of Resident #	T's CSCS dated (02/18/23				
	revealed:						
	-Hydrocodone-acetar						
	tablet every 6 hours v						
	of 60 tablets which wa						
	-There was documen						
	signed out was at 6:0	0pm on 03/05/23	•				
	Review of Resident #	1's CSCS dated (03/08/23				
	revealed:						
	-Hydrocodone-acetar	ninophen 5-325m	ig take 1				
	tablet every 6 hours v						
	of 60 tablets which wa						
-There was documentation that the first tablet			-				

signed out was at 12:00am on 03/09/23. -There was no documentation that

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034116	B. WING		R 05/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
		2609 OLD	SALISBURY R	•	
SALEMII	ERRACE AND MEMORY	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 358	Continued From page 24		D 358		
	hydrocodone-acetaminophen was signed out between 12:00am on 03/06/23 and 6:00pm on 03/08/23. Review of Resident #1's physician's order dated 04/06/23 revealed: -There was an order to discontinue hydrocodone-acetaminophen 5-325mg 1 tablet every 6 hoursThere was an order to start hydrocodone-acetaminophen 10-325mg take 1				
	tablet every 6 hours.	1'o April 2022 oMAB			
	Review of Resident # revealed:	i s aprii 2023 eiviar			
	-There was an entry f hydrocodone-acetami tablet every 6 hours s 6:00am, 12:00pm, an	inophen 5-325mg, take 1 cheduled at 12:00am, d 6:00pm with a			
	discontinued date of 04/06/23. -There was an entry for hydrocodone-acetaminophen 10-325mg, take 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 04/06/23.				
	6:00pm on 04/23/23 o				
	revealed: -Hydrocodone-acetan tablet every 6 hours w of 60 tablets which wa	tation that the last tablet			

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Review of Resident #1's CSCS dated 04/23/23

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		HAL034116	B. WING		05	R 5/ 03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		2609 OLI	SALISBURY ROA	ND		
SALEM II	ERRACE AND MEMORY	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	tablet every 6 hours of 90 tablets which word 90 tablets word 90 tab	ninophen 10-325mg take 1 vas dispensed for a quantity as a 22-day supply. tation that the first tablet 00am on 04/23/23. nentation that inophen was signed out e on 04/22/23 through the 3/23. 11's Progress Notes 14am, after missing two inophen, there was tesident #1 had been more ssive that morning. 14am, there was tesident #1 did not get her rocodone-acetaminophen titing on the delivery of the oharmacy. am, after missing two inophen, there was tesident #1 had been more of the oharmacy. am, after missing two inophen, there was tesident #1 had been more aff and other residents and foreaming. 11's hospice interdisciplinary assessment and plan of ted 02/24/23 revealed: ocumented that on 02/18/23 ated. ound a medication error 1 having been out of her	D 358	DEPICIENC		
	scheduled prescription hydrocodone-acetam	-				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
			A. BOILDING.		 R	
		HAL034116	B. WING		1	3/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEMITE	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD		
07122111112		WINSTON	I SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	58 Continued From page 26		D 358			
	and had a refill for the hydrocodone-acetam the pharmacy. -The hospice nurse p facility staff about the withdrawal symptoms compliance. -The hospice nurse in request medication request medication. -Resident #1's pulse missed 23 doses of hwas 90 beats per min from 01/27/23 through received hydrocodone bpm to 80 bpm) and 146/72 (her blood prethrough 02/23/23, on hydrocodone-acetam 124/68). Observation of medication medication of me	inophen prescription sent to rovided education to the medication error, and medication astructed facility staff to efills prior to the medication acility staff voiced on 02/18/23 when she had ydrocodone-acetaminophen aute (bpm)(her pulse range h 02/23/23, on the days she e-acetaminophen, was 59 her blood pressure was essure range from 01/27/23 the days she received inophen, was 100/60 to ations on hand for Resident 5pm revealed: ication cards containing inophen 10-325mg with a /23/23. If 90 dispensed tablets ication cards. eent #1 on 05/02/23 at e was sitting on the couch in /ake, and calm. dent #1 on 05/02/23 at /23 at 11:24am revealed she				
	Telephone interview v	vith a representative from				

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the facility's contracted pharmacy on 05/02/23 at

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034116	B. WING		05/0	3/2023
	ROVIDER OR SUPPLIER	CARE 2609 OLD	DRESS, CITY, STA SALISBURY RO SALEM, NC 2'	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	were dispensed for R quantity of 60 tabletsHydrocodone-acetar were dispensed for R quantity of 90 tabletsTelephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets. Telephone interview were dispensed for R quantity of 90 tablets.	ninophen 5-325mg tablets esident #1 on 01/27/23 for a ninophen 5-325mg tablets esident #1 on 02/18/23 for a ninophen 5-325mg tablets esident #1 on 03/08/23 for a ninophen 5-325mg tablets esident #1 on 03/20/23 for a ninophen 10-325mg tablets esident #1 on 03/28/23 for a ninophen 10-325mg tablets esident #1 on 03/28/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325mg tablets esident #1 on 03/28/23 for a ninophen 10-325mg tablets esident #1 on 03/28/23 for a ninophen 10-325mg tablets esident #1 on 04/23/23 for a ninophen 10-325	D 358			

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-The hospice nurse provided education to the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
			7.1. 20.123.110.			R
		HAL034116	B. WING		05	5/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY ROA	AD.		
SALEM T	ERRACE AND MEMORY	CARE	N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	facility staff about requesting refills at least a couple of days prior to the medication running out so they had time to reorder the prescription. Interview with Resident #1's hospice nurse on 05/03/23 at 10:40am revealed: -She had known Resident #1 since she was first admitted to hospice in February 2022Resident #1 was not able to communicate her needs due to her dementiaWhen Resident #1 ran out of hydrocodone-acetaminophen, she had been agitated and yelling out while laying in bedOn 02/20/23, when Resident #1 was back on her scheduled routine of taking hydrocodone-acetaminophen, staff had reported that she was more calm since taking the pain medication againHospice expected the facility staff to contact them when Resident #1 was down to the last several days' worth of dosesHospice was able to have a prescription refill at the pharmacy within a day.		D 358			
	(MCC) on 05/03/23 a -She and the medical notify the hospice sta their visits to the facil to wait for the prescri pharmacy and deliver -Usually, the hospice medication cart to se was remaining and st refillsThe MAs were exper in the eMAR when Re doses remainingShe was not aware to	tion aides (MAs) tried to ff of needed refills during ity, but then the facility had ption to be sent to the red to them at the facility.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED	
		HAL034116	B. WING		R 05/03/202	23
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	JE ZIP CODE	•	
TVAINE OF T	NOVIDER OR GOLF EIER		SALISBURY R			
SALEM TI	ERRACE AND MEMORY	CARE	SALISBURY R			
0/10/15	SLIMMADV ST		T .		N	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETE DATE
D 358	Continued From page 29		D 358			
D 358	February, March and -Some behaviors that refusing to get out of on her to bed rail and and being combative -She did not rememb behaviors during the hydrocodone. Interview with a MA or revealed: -She worked the day of hydrocodone-aceta 2023, and worked on had ran out of hydrocod-The hospice nurse of Resident #1 at least of MAs let the hospice in needed if the medical blue-shaded row (last cardShe thought she had the pharma prescription because doctor's written order -She let someone known hydrocodone prescription reordered, but she con-Resident #1 did not loor behaviors when she litterview with a second 3:15pm revealed:	April 2023. Resident #1 had included bed in the morning, holding shaking it, yelling at staff, with staff. er if Resident #1 had days she had not taken n 05/03/23 at 2:25pm before Resident #1 ran out aminophen in February 02/14/23 after Resident #1 odone-acetaminophen. 3/23 when Resident #1 had one-acetaminophen. ame to the facility to see once or twice a week and the nurse know that a refill was tion was down to the tallow to the tetaminophen in February ocy did not send the the pharmacy needed the the own about Resident #1's	D 358			
	-She worked the day	ocodone-acetaminophen. before Resident #1 ran out aminophen in April 2023.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: R B. WING D5/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SALEM TERRACE AND MEMORY CARE (X4) ID PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) (X5) COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING: R DEFICIENCY (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) ID PROVIDER OR SUPPLIER (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X5) COMPLETE DATE (X5) CROSS-REFERENCED TO THE APPROPRIATE DATE	Division of Health Service Regulation			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SALEM TERRACE AND MEMORY CARE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION)	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIF	ER/CLIA (X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING WINSTOR B. WING PREFIX (EACH CORRECTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE 05/03/2023	AN OF CORRECTION IDENTIFICATION NU	MBER: A. BUILDING:		COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING WINSTOR B. WING PREFIX (EACH CORRECTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE 05/03/2023				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE		B WING		
SALEM TERRACE AND MEMORY CARE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE	HAL034116			05/03/2023
SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE	OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE		2609 OLD SALISBURY R	OAD	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	M TERRACE AND MEMORY CARE			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE				(*)
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	,	1,10		
	- 			
D 358 Continued From page 30 D 358	Continued From page 30	D 358		
-When Resident #1's	When Resident #1's			
	**	a tha		
hydrocodone-acetaminophen was down to the last 8 tablets, the MAs were supposed to click the				
"refill" button in the eMAR, the pharmacy would				
send staff a notice that a written prescription was		on was		
needed from the doctor.				
-The MA would have to call hospice to request a	•	'		
refill, and they would send the prescription to the		ı to the		
pharmacy.	'			
-Once hospice staff sent the prescription to the		l l		
pharmacy, it would be delivered that same	1.5)		
evening.	9			
-Hospice could order	1 .			
hydrocodone-acetaminophen to be delivered right				
away and the facility would have the prescription	-	oription		
within hours.				
-She could not remember if she had requested a	-She could not remember if she had reque	ested a		
refill for Resident #1's	**			
hydrocodone-acetaminophen in April 2023.				
-She did not remember Resident #1 having		• 1		
increased agitation or yelling out on the days	increased agitation or yelling out on the da	ays		
when she did not take	when she did not take			
hydrocodone-acetaminophen.	hydrocodone-acetaminophen.			
-The MAs and the MCC did medication cart		l l		
audits every Monday, Wednesday, and Friday,	audits every Monday, Wednesday, and Fr	iday,		
but they had a rotation of which residents'	but they had a rotation of which residents'			
medications they audited.	medications they audited.			
-During the medication cart audits, they checked	-During the medication cart audits, they ch	necked		
the quantity of medications remaining.				
-She did not know why Resident #1 had ran out of		an out of		
hydrocodone-acetaminophen between refills in	hydrocodone-acetaminophen between ref	ills in		
February, March and April 2023 when the MAs,				
the MCC and the hospice nurse all did medication				
cart audits.				
Interview with a third MA on 05/03/23 at 3:40pm	Interview with a third MA on 05/03/23 at 3	:40pm		
revealed:				
-She had documented Resident #1's				
hydrocodone-acetaminophen as not administered		nistered		
three times in February 2023, four times in March				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		HAL034116	B. WING		R 05/03/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SALEMITE	RRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD	
OALLIN II	INVAGE AND MEMORY	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page 31		D 358		
	2023, and two times in Since the hospice nurse already knew it also sure already knew it also sure already knew it she ran out because nurse already knew it also sure already knew it also sure already knew it she sould not remensionereased agitation, but the days she did not the sould not remensionereased agitation, but the days she did not the sould not remensionereased agitation, but the days she did not remensionereased.	in April 2023. Irse came and counted odone-acetaminophen once did not request refills of the inophen any of the times she thought the hospice redded to be refilled. In occodone-acetaminophen of the inophen was would let the hospice for in-person visits. In occodone if Resident #1 had behaviors or yelling out on take			
	Interview with the Administrator on 05/03/23 at 4:00pm revealed: -The MAs were expected to request medication refills once the quantity remaining reached the blue-shaded, last column of the medication card. -The MAs were supposed to click the "refill" button on the eMAR, and when the pharmacy sent their note saying that a written prescription was needed, staff were supposed to call hospice with that information. -If the MAs first requested a refill of Resident #1's hydrocodone-acetaminophen when the quantity remaining first reached the blue-shaded column of the medication card, there would be enough time to get the prescription in the facility prior to it running out. -The pharmacy delivered medications in the morning and in the evening so if a medication refill was requested it either came that same evening or the following morning. -The MCC was supposed to be completing audits on the eMARs at the same time she was auditing the medication carts and each resident was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		HAL034116	B. WING		0.5	R / 03/2023
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 00	100/2020
SALEM T	ERRACE AND MEMORY	CARE	D SALISBURY ROA N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	hydrocodone-acetam the last three months -She expected refills medications running -She expected medic ordered. Based on observation review of Resident #2 2023 eMARs, and tel facility's contracted pi not administered a to hydrocodone-acetam through 04/30/23. Attempted telephone power of attorney (PC was unsuccessful. Based on observation interview, it was dete interviewable. b. Review of Resident 08/24/22 revealed an antipsychotic medical schizophrenia, bipola 100mg twice daily. Review of Resident # order dated 09/08/22 quetiapine order to ta afternoon and 100mg Review of Resident # order dated 01/27/23 -There was an order 50mg in the morning bedtime.	inophen between refills for to be requested prior to the out. ations to be administered as a form of medications on hand, and a first of the property of the pharmacy, March and April ephone interview with the harmacy, Resident #1 was tal of 41 doses of inophen from 02/01/23 at 11:32am and a first of the pharmacy of t	D 358			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND LEAN C	21 CONNECTION	DENTI IOATION NOMBER.	A. BUILDING: _		JONII LETED
		HAL034116	B. WING		R 05/03/2023
		HALUS4110			05/03/2023
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
SALEM TE	ERRACE AND MEMORY	CARE	SALISBURY R		
			N SALEM, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	2 3 3	D 358		
	three times daily.				
	Review of Resident # medication administrate revealed: -There was an entry f daily scheduled at 9:0-There was documen administered twice da 02/28/23There was an entry f bedtime scheduled at -There was documen was administered at 9through 02/28/23. Review of Resident # revealed: -There was an entry f daily scheduled at 9:0-There was documen administered twice da 03/31/23There was an entry f bedtime scheduled at -There was documen was administered at 9through 03/31/23. Review of Resident # revealed: -There was an entry f daily scheduled at 9:0-There was an entry f daily scheduled a	for quetiapine 50mg twice 200am and 5:00pm. Itation quetiapine 50mg was aily from 02/01/23 through for quetiapine 100mg at 9:00pm. Itation quetiapine 100mg 2:00pm from 02/01/23 1's March 2023 eMAR for quetiapine 50mg twice 200am and 5:00pm. Itation quetiapine 50mg was aily from 03/01/23 through for quetiapine 100mg at 9:00pm. Itation quetiapine 100mg at 9:00pm. Itation quetiapine 100mg at 9:00pm from 03/01/23 1's April 2023 eMAR for quetiapine 50mg twice			
	04/30/23.	oily from 04/01/23 through or quetiapine 100mg at			
		tation quetiapine 100mg			

Division of Health Service Regulation

was administered at 9:00pm from 04/01/23

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
						R
		HAL034116	B. WING		05	5/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
SALEM TI	ERRACE AND MEMORY	2609 OL	D SALISBURY ROA	AD.		
		WINSTO	ON SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	D 358 Continued From page 34		D 358			
	through 04/30/23.					
	05/01/23/ through 05 -There was an entry daily scheduled at 9:0There was documen administered at 9:00a and at 9:00am on 05 -There was an entry bedtime scheduled a -There was documen was administered at Review of Resident # group comprehensive care update report da -There was documen doctor increased Resito 100mg three time -There was documen	for quetiapine 50mg twice 00am and 5:00pm. Intation quetiapine 50mg was am and 5:00pm on 05/01/23, 1/02/23. for quetiapine 100mg at the 19:00pm. Intation quetiapine 100mg 9:00pm on 05/01/23. It is hospice interdisciplinary the assessment and plan of 10:00pm on 05/01/23 revealed: Intation that the hospice 10:00pm on 01/27/23. Intation from the hospice of 10:00pm on 01/27/23. Intation from the				
	group comprehensive care update report da - There was documed pastor/counselor that that Resident #1 had	t1's hospice interdisciplinary e assessment and plan of ated 03/24/23 revealed: ntation from the hospice tracility staff reported to her been yelling, cursing loudly er residents' feet with her				
	#1 on 05/02/23 at 2:5 -There were two med 50mg twice daily with 03/30/23; one medical	cation on hand for Resident 55pm revealed: dication cards for quetiapine n a dispensed date of ation card had 5 out of 30 maining and the second				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL034116	B. WING		05	R 5/03/2023
	ROVIDER OR SUPPLIER	2609 OL	D SALISBURY ROANN SALEM, NC 271	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	tablets remainingThere was one medi 100mg at bedtime wit 04/07/23 and had 12 remaining. Observation of Residential 1:40am revealed she the common area, aw Observations of Residential 2:49pm and on 05/03 was laying quietly in the facility's contracted 3:25pm revealed: -The current order the was 50mg twice dailyThe pharmacy did no 01/27/23 to increase dose to 100mg three. Telephone interview was to 100mg three. Telephone interview was 80mg twice dailyThe pharmacy did no 01/27/23 to increase dose to 100mg three. Telephone interview was reliable to 100mg three times daily and 100mg at bean order for quetiapinThe current order the medication list with he 100mg three times daily and	cation card for quetiapine th a dispensed date of out of 30 dispensed tablets ent #1 on 05/02/23 at e was sitting on the couch in vake, and calm. dent #1 on 05/02/23 at //23 at 11:24am revealed she ped in her room. with a representative from end pharmacy on 05/02/23 at ey had was for quetiapine and 100mg at bedtime. For receive the order dated Resident #1's quetiapine times daily. with representative for exphysician's office on revealed: spice doctor discontinued of the physician's office on revealed: spice doctor discontinued of the ine order for 50mg twice endtime and replaced it with exphand on Resident #1's pospice was quetiapine ailly. exility to be administering the etimes daily to Resident thospice doctor. scribed quetiapine to help the behaviors.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		_		R
	HAL034116	B. WING		05/03/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SALEM TERRACE AND MEMORY CA	2609 OLD	SALISBURY R	OAD	
SALEIW TERRACE AND WEWORT CA	WINSTON	SALEM, NC 2	7127	
PREFIX (EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358 Continued From page 3	36	D 358		
agitation and pulling hereason the hospice doc quetiapine dose to 100 -Resident #1 had conting quetiapine dose was in the hospice doctor woodose of her narcotic pathe behaviors could be -They were not aware to quetiapine dose was not was still receiving 50mg afternoon instead of 10 -There was documentate chaplain on 02/13/23 that agitated and pulling at -There was documentate nurse on 03/20/23 that at the facility reported to Resident #1 had been intentionally rolling over her wheelchair. -There was documentate nurse on 04/21/23 that exhibiting symptoms of during her visit. -Resident #1's ongoing yelling out could be condose not being increase. Interview with Resident 05/03/23 at 10:40am resident #1 was present anage her behaviors. -Resident #1's quetiapit three times daily. -She was not aware the receiving quetiapine 50 afternoon rather than 1 -Resident #1's behaviors.	er hair out, and that was the ctor increased the ling three times daily. In the description of the land of the line of the land of the lan	D 358		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DUILDING: _		
		HAL034116	B. WING		R 05/03/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CALEME	TODACE AND MEMORY	2609 OLD	SALISBURY R	OAD	
SALEMITE	ERRACE AND MEMORY	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	8 Continued From page 37		D 358		
	out.				
	(MCC) on 05/03/23 at a -When the hospice do orders, the order was -Once the faxed orde herself or a MA would the pharmacy, and witto indicate that it had -There were no initials Resident #1's dose of times daily, so she did order into the resident the pharmacy. -She had never seen Resident #1's quetiant -She only audited never came; she did not go records to review prevorders had been missing -Resident #1 had not of months, but she had	octor wrote new medication faxed to the facility. If arrived at the facility, either it take the order and fax it to rite their initials on the order been processed. If a continuous on the order to increase it quetiapine to 100mg three in the order to increase it record without faxing it to the order to increase in th			
	revealed:	n 05/03/23 at 2:25pm			
	 -When the hospice do medication order, the 				
		ne pharmacy or faxed the			
	order to the facility.	00 116			
	-Either a MA or the M	CC could fax new the pharmacy, but usually			
	the MCC took that res				
	-She had not seen the	e order to increase Resident			
		to 100mg three times daily.			
		ts were completed every ared the medication in the			

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cart to the medication order.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BOILBING.		_	
		HAL034116	B. WING		05/03	/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CALEMI	ERRACE AND MEMORY	2609 OLD	SALISBURY R	OAD		
SALEIVI II	ERRACE AND MEMORY	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 38		D 358			
	-The order in their eM quetiapine 50mg in the and 100mg at bedtim discrepancyThe pharmacy enters the eMAR, so if the period not get updatedResident #1 had behincluding yelling out of the second 3:15pm revealed: -If hospice wrote a new MCC was responsible by faxing it to the phanew order in the eMA-If the MCC was not we prescription order was hospice, then whoeves be responsible for prosponsible someon machine and put it into without faxing it to the Resident #1 sometime at staff or refusing peresident #1 had not previous couple of more linterview with a third revealed:	ARR system was still for the morning and afternoon the morning and and the morning and approve the morning and approving the the supervisor was would be provided to the facility from the supervisor was would be provided to the morning and approving the morning and approving the morning and approving the supervisor was would be provided to the morning and afternoon the order it me took the order off the fax to Resident #1's record to pharmacy. The morning and afternoon the morning and the morning and the morning and the morning and afternoon the morning and the mo				
	record, but they were	put it into the resident's supposed to check and see				

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doing so.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL034116	B. WING		05/03/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE AND MEMORY	CARE	SALISBURY R			
	WINSTON					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 39	D 358			
D 358	-She had not seen Reincrease quetiapine to -Resident #1 usually rather than second shown as well as we	esident #1's order to to 100mg three times daily, had behaviors for day shift nift when she worked. It have behaviors on ually just yelling out. Int #1 had a behavior when a couple weeks ago. ministrator on 05/03/23 at mailled for ensuring all new re faxed to the pharmacy. It is ponsibility to follow-up on ensure it had been the eMAR. It hat Resident #1's order to 100mg three times daily to the pharmacy or changed of Resident #1 having any because staff had not her. Resident #1 sometimes to be repositioned often. It dications to be administered interview with Resident #1's DA) on 05/03/23 at 11:32am	D 358			
		t #4's current FL2 dated agnoses included diabetes				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	SURVEY PLETED	
		HAL034116	B. WING		05	R 5/ 03/2023
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE	,	
		2609	OLD SALISBURY R			
SALEM T	ERRACE AND MEMORY	CARE WINS	STON SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	58 Continued From page 40		D 358			
	discharge instructions and 04/24/23 reveale -She was seen for vis abdomenThere were orders to vitamin supplement) to have a pharmacist recommendations. Review of Resident # electronic medication (eMAR) revealed: -There was no docum administered daily fro 03/31/23 and from 04 Review of Resident # 05/01/23 through 05/6-There was no entry f	sits for an open wound of the start taking vitamin A (a daily for wound healing and advise dosage 4's March, and April 2023 administration record for vitamin A daily. hentation that vitamin A was om 03/08/23 through 1/01/23 through 04/30/23. 4's May 2023 eMAR from 02/23 revealed: for vitamin A daily.				
	-There was no docum administered daily fro 05/02/23.	nentation that vitamin A was om 05/01/23 through				
		ent #4's medications on 2:00pm revealed there were e for administration.				
	the facility's contracted 3:18pm revealed: -Resident #4 did not livitamin A.	with a representative from ad pharmacy on 05/02/23 at mave a physician's order for				
	via fax on the facility's	received orders, they added				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL034116	B. WING		05/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SALEMIT	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD	
OALLIN II	ERROL AND MEMORI	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 41	D 358		
	on 05/03/23 at 1:20pi -There were two smathe right lower abdome centimeter in size and centimeters in size, wand initialed on 05/03 -There was no redness Interview with Resider revealed: -She went to the wou weeks for an open ar -She did not remembed clinic telling her she heshe did not see discontransporter took them back from appointme -She really needed exwounds to heal. b. Review of Resider discharge instructions and 04/24/23 revealershe was seen for visabdomenThere were orders to	Il open areas (wounds) on nen; one wound was 1 dt the second wound was 2.5 with an intact dressing dated 1/23. The second wound was 2.5 with an intact dressing dated 1/23. The second wound care dinic every 3 or 4 dea on her abdomen. The staff at the wound care and to start taking vitamins A. The harge papers because the second to the MAs when she got ants. The second wound care clinic estated 03/08/23, 04/10/23 dt. The second wound of the second wound of the second wound healing and			
	recommendations.	-			
	electronic medication (eMAR) revealed: -There was no entry f -There was no docum administered daily fro	nentation that vitamin C was			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURV COMPLETE	
			_		R	
		HAL034116	B. WING		05/03/2	2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE AND MEMORY	CARE	SALISBURY R			
			SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 358	Continued From page	e 42	D 358			
	05/01/23 through 05/0 -There was no entry f	or vitamin C daily. nentation that vitamin C was				
	Observation of Resident #4's medications on hand on 05/03/23 at 2:00pm revealed there were no vitamin C available for administration.					
	no vitamin C available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/02/23 at 3:18pm revealed: -Resident #4 did not have a physician's order for vitamin CThe pharmacy received orders electronically or via fax on the facility's order sheetsWhen the pharmacy received orders, they added the orders to the eMAR and dispensed the medications.					
	revealed: -She went to the wou weeks for an open are -She did not remember clinic telling her she had compared to the compared	er staff at the wound care had to start taking vitamins harge papers because the hother to the MAs when she got				
	discharge instructions and 04/24/23 reveale	nt #4's wound care clinic s dated 03/08/23, 04/10/23 d: sits for an open wound of the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL034116	B. WING		05	R 5/03/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
041 514 5		2609 OL	D SALISBURY ROA	AD .		
SALEM TI	ERRACE AND MEMORY	CARE WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 43	D 358			
	supplement) daily for	o start taking zinc (a mineral wound healing and to have dosage recommendations.				
	Review of Resident #4's March and April 2023 electronic medication administration record (eMAR) revealed: -There was no entry for zinc dailyThere was no documentation that zinc was administered daily from 03/08/23 through 03/31/23 and 04/01/23 through 04/30/23. Review of Resident #4's May 2023 eMAR from 05/01/23 through 05/02/23 revealed: -There was no entry for zinc dailyThere was no documentation that zinc was administered daily from 05/01/23 through 05/02/23.					
	_	ent #4's medications on 2:00pm revealed there were administration.				
	the facility's contracted 3:18pm revealed:	with a representative from ed pharmacy on 05/02/23 at have a physician's order for				
	-The pharmacy receiving fax on the facility! -Whenthe pharmacy	ved orders electronically or s order sheets. received orders, they added AR and dispensed the				
	revealed: -She went to the wou weeks for an open ar -She did not rememb	ent #4 on 05/03/23 at 1:45pm and care clinic every 3 or 4 rea on her abdomen. er staff at the wound care and to start taking zinc.				

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1 3 4		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BUILDING: _			
		HAL034116	B. WING		05/0	3/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE AND MEMORY	CARE	SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	2 44	D 358			
	transporter took them back from appointme	harge papers because the to the MAs when she got nts. ktra nutrition to help her				
	orders for vitamins A wound care clinic. -The facility sent a pheach appointment to orders. -The MAs would not hapges of discharge in the facility's order sheelf the Resident Care in the facility, the mediated the order sheet placed all paperwork. -The pharmacy added eMAR and sent the mext morning. -The RCC received a residents returned from	er Resident #4 ever having and C or zinc from the ysician's order sheet for write order changes or new have looked through the structions because they had set. Coordinator (RCC) was not dication aide (MA) on duty to the pharmacy and then				
	Resident #4's primary office on 05/03/23 at -Resident #4 was refectinic for an abdomina -The PCP would experience of the	erred to the wound care				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034116	B. WING		R 05/03/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY RO	OAD		
SALEM T	ERRACE AND MEMORY	CARE WINSTON	SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	
D 358	B Continued From page 45		D 358			
	and electronic, written or verbal ordersThere was no documentation facility staff requested prescriptions for vitamins A and C, and zinc daily.					
	Resident #4's wound 4:46 revealed: -Resident #4 had bee wound to her abdomeThe discharged instr 03/08/23 and afterwa for vitamin A and C, a healingIf the facility needed they should have conprescriptions would helectronically to the relative was expected that medications, even if the total administer them.	uctions for Resident #4 on rd were considered orders and zinc daily for wound orders written differently, tacted the office and ave been written or sent esident's pharmacy. the facility would obtain the hey were over the counter, to Resident #4. to negative effects if eceive the vitamins A and C,				
	revealed: -He reviewed the resireturned from appointance: -The facility sent and that the wound care part care orders on, but not zincHe would not have look her discharge summate facility's signed order itHe missed the instru	dents' orders when they tments. order sheet with Resident #4 provider had written wound of the vitamins A and C, and poked through the pages of ary, because he had the sheet with other orders on to start vitamins A and C.				

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and zinc daily.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BOILDING.			
		HAL034116	B. WING		05/03	3/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CALEMI	EDDACE AND MEMORY	2609 OLD	SALISBURY R	OAD		
SALEIVI II	ERRACE AND MEMORY	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 46	D 358			
	-If he had seen the in called the PCP and re to the pharmacy.	structions, he would have equested orders to be sent				
	2:15pm revealed: -She was not aware t instructions on a disc	harge summary to start				
	taking vitamins A and C, and zinc daily. -The RCC reviewed the facility's order sheet that was sent with resident's going to appointments. -She did not expect the RCC to review					
		harge summary, because it the facility's order sheet. ic provider did not list				
		d zinc with dosages on the and so those orders were				
	-She expected all phy	vsician's orders to be cations administered as				
	administered as order a resident who had an medication due to an	nsure medications were red for 2 residents including n order for a narcotic pain end of life terminal illness				
	for 24 doses in Febru 5 doses in April 2023	ne narcotic pain medication ary, 12 doses in March, and resulting in the resident increase in her blood				
	and an order to increa	ate, and exhibiting agitation; ase the dose of an tion that was prescribed for				
	subsequent ongoing l yelling, and being cor	never increased resulting in behaviors of pulling her hair, mbative (Resident #1); and a administered her vitamin				
	and mineral supplement healing (Resident #4)	ents needed for wound				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDEITH IO/HIGH HOMBER.	A. BUILDING: _			
		HAL034116	B. WING		R 05/03/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
SALEM TE	ERRACE AND MEMORY	CARE	SALISBURY R			
		WINSTON	SALEM, NC 2	T.		_
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	i .
D 358	Continued From page 47		D 358			
	harm and neglect which constitutes a Type A2 Violation.					
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 05/03/23 for				
	CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, JUNE 2, 2023.					

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